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# THE MANAGER

MANAGEMENT STRATEGIES FOR IMPROVING HEALTH SERVICES

## In This Issue



## Case



MSH MANAGEMENT SCIENCES *for* HEALTH

# Managing Performance Improvement of Decentralized Health Services

## Editors' Note

IT IS CRUCIAL FOR LOCAL GOVERNMENTS to manage basic health services effectively in countries undergoing decentralization, as district or municipal health administrations become more responsible for managing services and mobilizing resources. Experience in many countries shows that it is possible to improve services rapidly while strengthening the capabilities of health teams. Health teams become more skilled in collecting and analyzing data and in solving problems and more self-reliant in fulfilling their responsibilities for protecting the health of the populations they serve.

This issue introduces a highly participatory approach to developing district managers' skills and improving performance. This learning-by-doing approach to improving the management and performance of health services has proven effective at the local level in the context of health system reform and decentralization.

THIS ISSUE OF *THE MANAGER* will help managers at all levels understand the principles of local-level performance assessment and improvement. It also presents the concept of essential public health functions as a useful policy framework for decentralizing service management while maintaining and improving the coverage and quality of services. ■

THE MANAGER



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# Strengthening District Management and the Performance of Health Services

Ministers of Health and those in charge of planning and managing health services want managers at the provincial and district levels to perform well and take responsibility for carrying out essential public health functions according to defined standards. Health service managers often wish they could solve their own operational and resource problems with less reliance on the central ministry and programs. Increasing managers' ability to function independently to a high standard has become a requirement for successful decentralization in many countries.

Management of performance improvement (MPI) is a learning-by-doing approach that helps managers at decentralized levels improve health services. This approach has been refined over 30 years and successfully applied in countries at all levels of development. It can be applied when:

- the national government or health sector has established policies for giving more authority and responsibility to subnational levels;
- the government wants to build capabilities at those levels quickly;
- the government has defined packages of health services and essential public health functions it is responsible for delivering to the entire population;
- there are national or international funding opportunities, such as performance-based contracts, that encourage provinces and districts to formulate their own projects for improving health service performance;
- partnerships between different levels of government (provinces and districts, for example) are being formed to share resources for improving health services;
- new national programs or externally funded projects require provinces or districts to develop innovative strategies to improve services or solve operational problems.

Anyone involved in the delivery of health services, including administrators at the national, provincial, and district or municipal levels who are addressing the challenges of decentralization, can use MPI. If you are a supervisor or manager, you can apply MPI to improve or design health services to address high-priority health problems and develop local capacity in program assessment, planning, and implementation. You can use MPI to solve performance problems in local health offices and centers, service delivery, and management support systems. MPI aims to help achieve the result that all health organizations desire: high-quality, sustainable health services supported by community action that contributes to improving health.

This issue was written by Stephen Sapirie and Robert Timmons. Stephen Sapirie, the Director of MSH's Information for Management Program, has long been involved in developing and applying the MPI approach. He has supported its design and implementation in Indonesia, the Philippines, and Afghanistan. Robert Timmons, the Team Leader for the Management & Leadership Program in Indonesia, and colleagues helped develop and have successfully used the approach in the Philippines and Indonesia.

# Understanding Management of Performance Improvement

MPI is a process in which district health teams learn to manage their own performance improvement. Performance improvement is a systematic process for improving health services in which district or municipal teams assess current health problems and service performance and make and implement a plan to improve the performance of selected services in a short time. Teams engage stakeholders, consider the environment and institutional context, describe desired performance, and identify gaps between desired and actual performance. They then analyze the causes of problems; select, design, and implement strategies to address those causes; and use monitoring and evaluation to measure changes in performance.

The purpose of MPI is to improve the performance of health services—and ultimately the health of target population groups—by expanding the coverage and quality of cost-effective interventions.

MPI focuses on reducing specific health problems through means available to health services and the communities they serve. In most cases, each team addresses only one or two serious health problems. Teams create, apply, and share their own solutions to these high-priority problems, thereby increasing their skills in using data. These solutions must meet nationally and locally defined health objectives and service functions, targets, and performance standards.

The MPI process goes beyond assessment, planning, and implementation of plans to include advocacy for support and resources. Teams develop and present proposals for innovative approaches as part of the MPI process and sometimes receive special funding to carry them out.

## Using MPI

If you are a manager at the national, provincial, regional, or district levels, you can use MPI to:

- address specific high-priority health problems, such as maternal mortality or childhood malnutrition;
- build the capacity of provinces or districts to assess, plan, implement, and monitor health services;
- engage provincial or district health offices in implementing new public health policies;
- involve provincial or district offices in planning new programs or strategies, such as HIV/AIDS prevention, malaria control, and DOTS for tuberculosis;
- help district planning teams prepare proposals for special grants or funding opportunities;
- engage districts or municipalities in designing local public health systems and procedures, for disease surveillance and outbreak control, for example.

### Origins and Results of MPI

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| DISTRICT TEAM PROBLEM-SOLVING | MPI is based on district team problem-solving (DTPS), which the World Health Organization (WHO) developed and has successfully applied in many countries for 20 years. Over the years, health planning methods supported by WHO have ranged from project planning to sectorwide planning (country health programming to meet the goals of Health for All) and eventually district-level planning. |
| EXPERIENCE IN INDIA | DTPS arose in response to a request from the Director of Health Services of Gujarat State, India, who wanted to increase the management capabilities of district medical officers through some kind of action learning. WHO found that district and service staff could carry out the project planning steps, even with limited data, and implement and evaluate the proposals they developed. After that experience, WHO extended the DTPS approach to other states in India. |
| EXPERIENCE IN OTHER COUNTRIES | The Public Health Institute in Kuala Lumpur, Malaysia, undertook the first formal application of DTPS in the present style (using four teams and a structured analysis and planning process) in 1985. WHO then applied DTPS in about 40 other countries, from Malawi to Mexico, over the next two decades. |

HOW MPI DIFFERS FROM DTPS

MPI uses procedures based on DTPS that are tailored to respond to the unique requirements of each country's approach to health system reform. MPI can be adapted to meet the needs of different countries and rapidly replicated in more sites in a country.

IMPACT ON HEALTH

Evidence of impact on health is available from several countries that have used MPI and its predecessor methodology, DTPS. For example:

- reports submitted by 381 local government units in the Philippines in 2003 showed that almost all (97%) had reached targets for vitamin A supplementation for children under five (96%), tetanus toxoid vaccination for pregnant women (80%), full immunization of children aged 12 to 23 months (63%), and use of modern methods of contraception (48%);
- a report from the Ministry of Health of the Republic of the Maldives in 1996 listed the following accomplishments among its four participating atolls: the proportion of eligible couples who use any method of child-spacing rose from 15 to 45%; anemia in pregnancy declined from 28 to 22%; the proportion of islands on which contraceptives are easily accessible rose from 20 to 100%; the percentage of women with birth intervals of at least 36 months increased from 39 to 66%;
- a report on problem-solving by local teams from Veracruz, Mexico, in 1996 cited the following achievements: deaths due to diarrhea in children under five were reduced by 75%; the use and prescription of oral rehydration solution (ORS) by private physicians increased from 44 to 100%; and the percentage of mothers trained in the use of ORS increased from 13 to 87%.

## Recognizing the Benefits of MPI

The MPI process is structured so that a team or several teams of selected district or municipal staff can produce specified information in standard formats. MPI fosters consideration of the many variables that affect health programs, and it connects inputs to outputs by linking planning, monitoring, and follow-up. Specific benefits include encouraging innovation, building people's capabilities, improving the use of information, engaging stakeholders, and encouraging local empowerment in decentralized systems.

**Finding new ways to deliver services.** Using MPI, you can improve the performance of local services independently, but within the context of local annual and midterm planning and budgeting, and the national health framework of policies, strategies, programs, and management procedures. Innovations in service delivery often emerge from district team planning and implementation efforts. The national health administration can use such innovations as a way to test policy options.

**Building people's capabilities.** The primary purpose of MPI is to solve operational problems and improve health service performance. The process is also very effective in building the planning, management, and leadership capabilities of district health service management teams. Team members learn techniques of analysis and planning, and methods they can apply in their everyday work. Because the teams do the work themselves and make their own decisions in every step, they "own" the products. MPI fosters team spirit and efficient working relationships, builds confidence, and fosters a sense of individual and team accountability.

*In Thailand, after a series of MPI-style analysis, planning, and implementation efforts, the Ministries of Health and of Interior recognized key staff for their accomplishments. Several of these individuals were eventually appointed Directors-General in the Ministry of Health. Others became leaders of important health institutions.*

**Improving the use of information.** The high degree of quantification throughout the process helps build individuals' and teams' skills in using routine and sur-

vey data. In every step, team members use data for analyzing current performance, designing interventions for improving performance, monitoring progress and performance trends, and evaluating the effectiveness of interventions. Thus, health data collection, analysis, reporting, and routine health service monitoring improve, not only for the services chosen but for all services. In fact, some managers consider MPI to be the most effective approach to improving the design and use of a health management information system.

**Engaging stakeholders in creating a district performance improvement strategy.** The MPI process improves collaboration by facilitating communication among government decision-makers and across sectors using common concepts, terms, and methods. The facilitating organization continues to support the district teams after implementation begins by visiting the districts to help monitor progress and problems, and help prepare for evaluations and sharing of results with other teams. And since district teams normally find it necessary to call upon communities, local political leaders, nongovernmental organizations (NGOs), other public-sector groups, and the private sector to help design and implement their strategies for performance improvement, the result is often a broad-based health development strategy.

**Achieving local empowerment in decentralized health systems.** MPI supports phasing in of decentralization of authority and accountability and gradually improves management capabilities. MPI is a good approach for developing human resources for decentralized health services: local managers who are accountable, self-reliant, and capable of planning and managing health services.

## Applying MPI Terms and Concepts

Where health systems are decentralized, MPI teams often use the concept of *essential public health functions (EPHFs)* to design local programs. EPHFs are the health services that the government is obligated to deliver for its entire population and the other functions it must perform. EPHF policy often includes coverage targets and quality standards.

### What Are Essential Public Health Functions?

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|---|---|
| ORIGIN OF THE CONCEPT OF EPHFs | In the 1990s, as international organizations were responding to the needs of the countries of the former Soviet Union, it became apparent that certain health services and functions should be labeled "essential" and given priority for re-establishment in the health systems of the Newly Independent States. This experience led to the realization that "there are certain public health functions that are so important, and so cost-effective for maintaining and improving the health of the population, that countries at all levels of development should be encouraged and supported to enable these functions to be delivered to a certain minimum level of performance." |
| EVOLUTION OF THE CONCEPT | This concept was refined through a global survey in which 145 public health leaders from around the world developed a consensus list of EPHFs and defined their purpose and use at the global and national levels. Since then, a number of countries have created their own sets of EPHFs for purposes of establishing public health policy and standards of service, and the EPHF concept has become part of the action agenda of the World Federation of Public Health Associations. |

Source: Sapirie 2001

Planning is based on quantitative definitions of health, service, and resource problems. These definitions should be developed after careful epidemiological analysis of the problems. The process includes formulating quantified, time-limited health objectives and service targets aimed at achieving national and international health goals. The local managers and staff responsible for implementing performance improvement strategies design those strategies, drawing on innovative ideas as well as national service strategies, procedures, and standards. The glossary that follows defines basic MPI terms and concepts.

## Glossary of MPI Terms

| | |
|---|---|
| **health objective** | A statement that specifies the desired reduction in a selected health problem that is expected to be achieved within a specified period. |
| **indicator** | A measure of health status, service performance, or resource availability that enables monitoring of objectives, targets, and service performance. |
| **MPI monitoring and evaluation** | The collection and analysis of data for monitoring health problems, service performance, constraint reduction, and strategy implementation using specified indicators. |
| **MPI strategies** | Interventions chosen by an MPI team for achieving stated health improvement objectives and service improvement targets. |
| **monitoring framework (Health Watch)** | Indicators, data collection methods, and data sources chosen by an MPI team to monitor a set of important and related health problems, services, constraints, and implementation milestones. |
| **problem definition** | A quantified statement that includes indicators of health problems, services that respond to those problems, and constraints that affect service performance. |
| **service target** | A statement that indicates the amount of improvement required in the coverage and quality of selected services, and in client satisfaction with those services, to achieve a specific health objective. |

## Designing an MPI Program Tailored to Your Situation

Improving the management of performance begins when a team of facilitators and central- and regional-level planners and supervisors customize the MPI process to respond to the needs of their particular situation. If you are leading an effort to improve performance in your country, region, or province, first review the conditions in which the approach can be used (see page 3). Talk with stakeholders from different levels. Then start by designing your own strategy for implementing the approach. Your strategy will include developing a customized process for engaging districts—before MPI begins. Each situation in which MPI is carried out varies in terms of political, organizational, and epidemiological factors, as well as national and donor priorities and interests. Therefore, your process must be tailored to meet the needs of the local situation.

During the design period, you develop and test the performance assessment methodology and planning process. You will need to work with the Ministry of Health (possibly a unit in charge of decentralization), a university with expertise in evaluation and health planning, groups that specialize in support systems related to performance, and the sponsoring donor, if there is one.

### Define Roles

Have a senior decision-maker (usually a Ministry of Health official) initiate the MPI process by assigning responsibility to district teams for carrying out the process. Sometimes a political leader, such as a governor or mayor, opens and closes the planning phase. These leaders assign the teams specific health problems to address or provide criteria for priority-setting and ask teams to choose their own high-priority problems and related services for performance improvement.

**Core facilitation team.** You and a small team of central and provincial facilitators will begin the program, develop the process and materials, and maintain them during the initial years. The core facilitation team should comprise knowledgeable, well-prepared staff from the Ministry of Health and regional health offices and possibly from NGOs and special projects.

The ideal facilitator for the process will be an experienced health service manager, epidemiologist, health planner, or financial manager. She or he will know how to make effective presentations and be skilled in advising teams about procedures and forms, without doing their analytical or planning tasks for them.

The facilitators prepare for MPI by helping design and becoming familiar with the process and its steps, products, and terminology. New facilitators learn by doing, with guidance from advisors who have extensive experience with MPI.

The facilitators prepare, test, and finalize customized session guides and forms. During the MPI process, the facilitators' role is to give the teams minimal guidance by answering questions about procedures and terminology. You and the facilitators should not interfere in team discussions and decision-making. Facilitators do not give lectures but provide only short briefings about the objectives and expected products of each step.

**District teams.** Teams are composed of about five to seven people, whom you should choose after the assessment phase. Involve the district and facility staff who will be responsible for carrying out the services that will be the subject of performance improvement. (These participants may not be the same as the people who carried out the performance assessment.) The planning team members must be available all day, every day, throughout the planning. They should be knowledgeable about the health problems selected (if those problems are known in advance). It is ideal to include some community practitioners. *For example, traditional birth attendants contributed to district team problem-solving in Tabasco State, Mexico, and some schoolteachers and magistrates were on problem-solving teams in the Maldives.*

### Develop the Guide and Forms

Facilitators support the MPI process with self-explanatory guidance materials. Learning-by-doing requires a clearly structured guide presenting the sessions, tasks, and forms for each step. This guide may also provide brief criteria for decision-making. A set of forms, similar to the examples on pages 11–16, but tailored to fit your adapted MPI process, should accompany the guide. The district teams use these forms to record their decisions and present their plans for each step.

Sometimes teams of MPI facilitators also produce facilitators' notes, which suggest the time needed for each session, tactics for clarifying the tasks in each step, and methods for brainstorming and arriving at consensus. These notes can be gradually assembled as facilitators gain experience with MPI.

Facilitators may also wish to give the district teams national service standards and protocols to remind them of the technical strategies to be implemented, but these materials should be brief and relevant to the problems being addressed by each team. *A Guide to Planning Local Government Health Services: The Matching Grant Program in the Philippines (MSH 2003a)* may be helpful because it contains detailed analysis and planning steps and forms. But the essential material is your own locally prepared and tested assessment and planning guidelines, developed to suit your district situation.

## Preparing for an MPI Program

### Establish the MPI Timetable

After the facilitation team designs the process as a whole, you set the timetable for the MPI process in your district. MPI usually has five phases, as shown in the following table.

**Phases of MPI (in One District)**

| Phase | Time Required | Products |
|---|---|---|
| **Preparation** | 2–4 weeks | ■ Understanding by district service managers of requirements for MPI |
| **Performance assessment** | 2–4 weeks | ■ Performance data and information related to EPHFs (all or selected functions) |
| **Planning** | 5–10 days | ■ Problem definition<br>■ Objectives and targets<br>■ Strategy<br>■ Performance improvement plan<br>■ Budget<br>■ Monitoring framework (Health Watch Form)<br>■ Proposal |
| **Implementation** | 6–18 months | ■ Mobilization of support and resources<br>■ Community involvement<br>■ Completed activities per plan<br>■ Progress and performance monitoring<br>■ Follow-up actions |
| **Evaluation** | periodic (scheduled) | ■ Reports on results of implementation, service performance improvement, and impact on health, according to the evaluation framework designed during planning |

## Make Arrangements for the Planning Process

After the facilitators have designed the process and you have made necessary preparations, they invite districts to participate in assessment and planning. As the manager of the process in your district, inform your team members about benefits to them as an incentive for committed participation. *In the Philippines, for examples, teams engaged in MPI knew that they would be the beneficiaries of matching grants from the Department of Health.*

**Arrange the site for the planning process.** Make arrangements to conduct the planning process in health service, district, or provincial facilities rather than rented accommodations to foster the sustainability of the process. The accommodations should have a reliable source of electricity and space for plenary and small-group work. It is preferable for all team members to be housed near the planning site.

**Brief stakeholders about their roles.** Involve district political leaders and service managers in the process from the beginning to encourage their continued support.

**Make sure equipment is available.** Arrange to have overhead projectors (and possibly an LCD projector) and at least one laptop computer available per team. You may need sound equipment if the group is large. Each working group will need a flipchart easel with a pad of paper and set of markers.

## Prepare Data

You need to make sure the district health office has provided analyses and summaries of health data. The district team can prepare the data needed during planning in one of two ways; in either case, teams use these data to define priority needs and identify districts or subdistricts for performance improvement. One way is simply to assemble the data and record it on the required forms. To do so, the district team works with existing recorded, reported, and survey data for about two weeks before the planning process begins.

Another approach is to design and carry out a rapid performance assessment, which may include modest cluster surveys or lot quality assurance sampling (see page 16) of communities. The facilitators usually design the forms for the required data but let each team design its own methods for collecting the data. You or the facilitators should offer guidance on selecting the survey samples.

### Tips for Designing an MPI Program

If you are a manager at the central, regional, or provincial level, you can begin to improve the management of performance in your districts by gathering a team of facilitators and central and regional planners and supervisors to design an MPI process that responds to the needs of your situation. When you design your initiative, consider its leadership, institutional home, coordination, and financing.

| | |
|---|---|
| LEADERSHIP | Seek support from the most senior technical leader involved in change in the health system. Update this manager regularly about the progress of the program and any problems. |
| INSTITUTIONAL HOME | While a temporary unit or health planning department can manage MPI initially, you will need to establish an institutional home for the process. This institution will provide qualified staff to develop and maintain the procedures and expand the corps of facilitators. If the institutional home is in a university, it should have close links with the ministry and benefit from its sponsorship and support. |
| COORDINATION OF EXTERNAL AGENCIES | MPI may require financial and technical support from international agencies and donors such as the US Agency for International Development (USAID) and WHO. |
| FINANCING | Some donors or countries use performance-based payment mechanisms, such as incentives or grants for achieving health objectives and service delivery targets. The MPI process can use such financing mechanisms at the district level when district plans are being formulated and during their implementation. Although performance-based incentive payments offer promise, they may undermine sustainability if external donors provide the funds. Incentive payments may also motivate inaccurate reporting. Special procedures are needed to ensure that the requirements of the incentive or grant are observed and that the required performance data are correctly assembled and presented. Please see "Using Performance-Based Payments to Improve Health Programs," *The Manager* (vol. 10, no. 2, 2001) for more information. |

## Carrying Out the Planning Phase

The MPI planning phase usually lasts 5–10 days. It often involves more than one district team at the same time. Limiting the time for planning helps keep the steps basic and relevant, which means that the districts will be able to reproduce them on their own. The participating teams use their own data (routine and survey) to generate the standard products required in each step.

Each session has clear objectives, guidance materials, tasks, and forms. (See the sample agenda below.) Every team must complete assigned tasks and products within the time allowed (or complete the work in the evening). This strict timetable helps the teams to improve their teamwork and efficiency. During the planning process, subgroups of the district teams share their products with each other to encourage generation of ideas. The following table illustrates typical steps in the planning phase.

**Example from Indonesia: Agenda for the Planning Phase**

| Day | Step | Session | Activities or Products (Completed Forms and Other Results) |
|---|---|---|---|
| Day 1: morning | | Opening of the MPI Process | Participants understand the objectives, products, and format of MPI. |
| | 1 | Produce the Problem Table and Causal Diagram | Health Problem and Service Indicators<br>Causal Diagram |
| afternoon | 2 | Identify Critical Service Tasks and Resources | Critical Service Tasks and Types of Resources Required |
| Day 2: morning | 3 | Formulate Objectives and Targets | Problem Reduction Objectives and Service Performance Targets |
| | 4 | Analyze Constraints | Service Constraints and Underlying Causes<br>Completed Table of District Objectives and Targets |
| afternoon | 5 | Design the Strategy for Performance Improvement | Ideas for Overcoming Constraints<br>Strategy for Improved Performance<br>Revised List of Critical Tasks and Resources Required<br>Priority Subdistrict (Health Center) Targets |
| Day 3: morning | | Design the Strategy for Performance Improvement, *continued* | |
| afternoon | 6 | Create the Performance Improvement Plan | Performance Improvement (Implementation) Plan |
| Day 4: morning | 7 | Prepare the Budget | Required Routine Service Budget<br>Development Budget to Implement the Performance Improvement Plan |
| afternoon | 8 | Plan Advocacy | Issues for Advocacy<br>Advocacy Plan |
| Day 5: morning | 9 | Design District Health Surveillance and Performance Monitoring and Evaluation | District Health Watch Framework<br>Surveillance Procedures |
| afternoon | 10 | Finalize the Proposal | Proposal for Service Performance Improvement |
| Day 6: morning | | Closing | Presentation of proposals<br>Discussion of follow-up actions<br>Results of participants' evaluations |

The following sections summarize the planning steps for one priority health problem for one team, although several teams may be working at the same time, and each team may be dealing with two or more problems. The problem is cases of severe diarrhea in children under five years of age.

## Step 1: Produce the Problem Table and Causal Diagram

In step 1, the district team members decide on the indicators they wish to use to measure the selected health problems and performance of related essential health services. Have them place these two sets of indicators into a three-part problem table like the one below.

### Health Problem and Service Indicators

**District:** _____ **Priority Health Problem:** Diarrhea in Children under Five (U5)

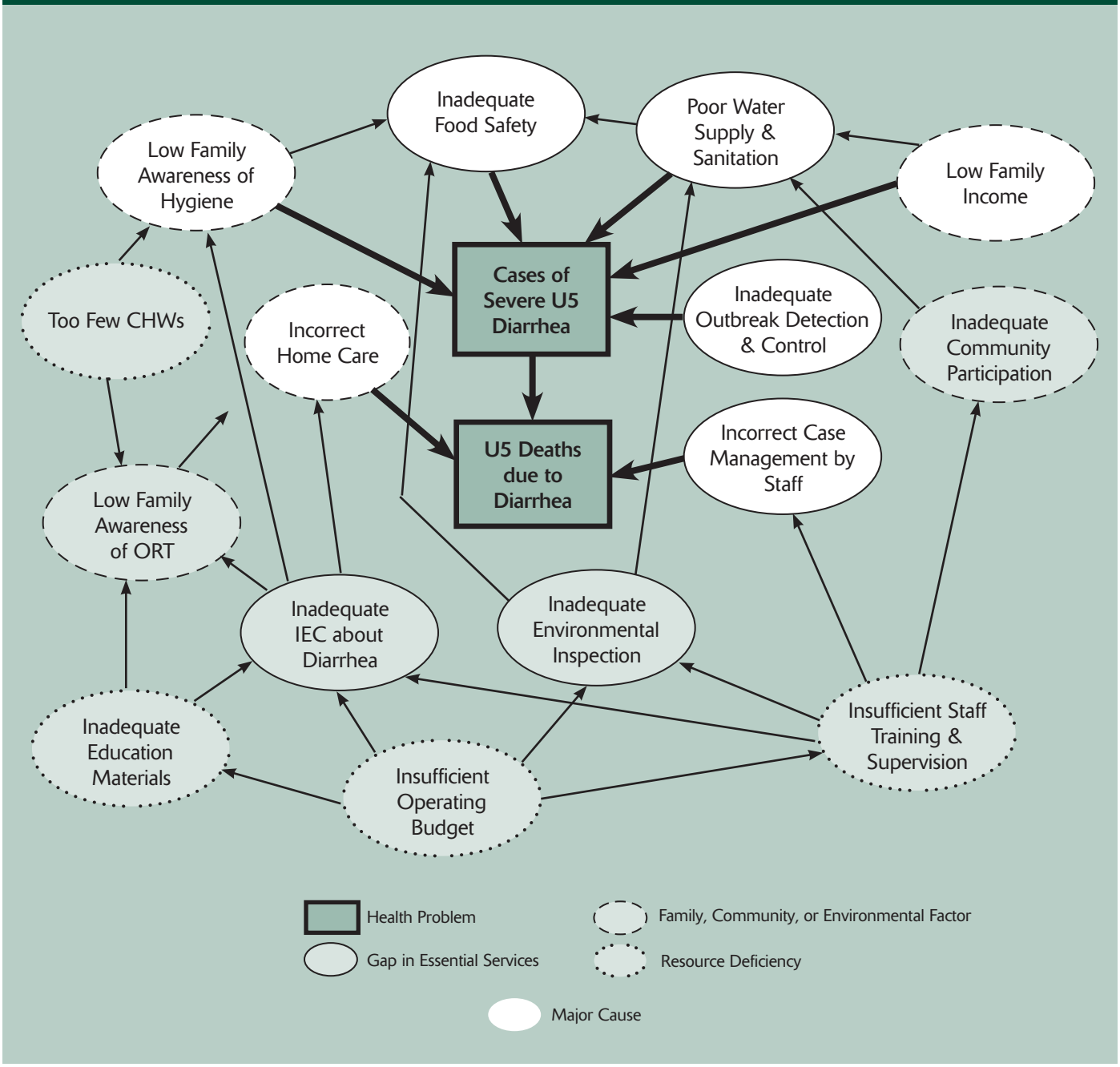
| Health Problem | | | Service Performance | | | Constraints | | |
|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Baseline** (2002) | **Trend** (2000–02) | **Indicator** | **Baseline** (2002) | **Trend** (2000–02) | **Indicator** | **Baseline** | **Trend** |
| U5 cases of severe diarrhea | 13,370 cases (est. at 5% of U5s per year) | Increasing | Population covered with safe water and sanitary excreta disposal | Urban: 60%<br>Rural: 25% | Steady<br>Declining | Completed during step 4 | | |

Extract the supporting data for the table from data collected during the assessment phase.

A complete problem table would include more rows for indicators defining the extent of the health problem and the performance of essential services. These could include the percentage of children under five with symptoms of diarrhea within the previous two weeks, proportion of infants under six months who are exclusively breastfed, and cases of severe dehydration and deaths due to diarrhea. See step 4 for instructions on how to complete the constraint section of the table.

Next the team discusses the major causes of the problem outcomes (in this example, deaths and cases of diarrhea in children under five) and constructs a diagram showing the relationships between causes and effects. The following diagram illustrates how four types of problem factors can be shown using different shapes. The white shapes indicate major causes and have thick arrows indicating their strong relationship with the effects. Thin arrows indicate weaker relationships. *In this example, incorrect home care and incorrect case management are major causes of deaths from diarrheal disease in children under five, but other factors, gaps, and deficiencies contribute to those causes.*

## Causal Diagram: Diarrhea in Children under Five




## Step 2: Identify Critical Service Tasks and Resources

In this step, the team defines the critical service tasks for preventing and managing the priority health problem and the current service volume of those tasks. They also identify the key resources needed to deliver the essential services and determine the current availability of those resources. They record these services and resources in a table that they can refer to when they design the performance improvement strategy.

## Step 3: Formulate Objectives and Targets

In the next step, the team discusses the problem indicators and trends, trends in service performance, and resources. Then they set objectives for reducing the problem and targets for improving service performance. They use the policy framework of the national essential public health functions to help them set these objectives and targets. They also draw on their knowledge of the local epidemiological situation and consider access to services.

**District Objectives and Targets to Decrease Diarrhea-Related Morbidity and Mortality**

| Health Objectives | | | Service Targets | | | Constraint Reduction | | |
|---|---|---|---|---|---|---|---|---|
| Indicator | Baseline | Objective | Indicator | Baseline | Target | Indicator | Baseline | Target |
| No. of cases of severe diarrhea among U5 age group | Estimated 200 per year | Reduce by 50% to 100 | Inspection of community water and sanitation | 25% of villages | 75% of villages | Completed during step 4 | | |
| % infants < 6 months exclusively breastfed (EBF) | 40% EBF | 80% of infants < 6 months EBF | Families educated about the value of breastfeeding | 35% | 80% | | | |

## Step 4: Analyze Constraints

After setting health objectives and service targets, the team carries out an analysis to identify the difficulties they can expect to encounter as they work to achieve their objectives and targets. You should encourage the team to think beyond the typical challenges such as lack of knowledge on the part of community members or resource shortages. Mention that staff knowledge, service providers' attitudes toward clients, and day-to-day performance problems also constrain the achievement of service targets. Invite the team members to list the constraints that they believe affect the targeted services the most. After they identify the underlying causes for each constraint, they can prioritize the constraints to be addressed in the strategy for performance improvement.

The team is now ready to complete the table in step 3 by defining indicators for measuring the most important constraints and placing the indicators in the table. Complete the table of objectives and targets by setting targets for reducing priority constraints and placing them in the three right-hand columns of that table, as shown below.

| Constraint Reduction | | |
|---|---|---|
| Indicator | Baseline | Target |
| No. of sanitarians trained in inspection of water supplies | 2 | 10 |
| % of mothers aware of diarrhea prevention and management | 15% | 75% |

## Step 5: Design the Strategy for Performance Improvement

In step 5, the team engages in brainstorming to generate ideas about reducing constraints to improving the coverage and quality of services. The strategies may include ideas for mobilizing participation and support from communities, NGOs, and other sectors, and other ways of generating additional support. The first product of this step is a long list of all the ideas expressed. Then the team should organize the ideas as strategies related to the service target to which they are expected to contribute. The table below gives an example.

**Ideas for Overcoming Constraints and Achieving Service Targets**

| Service Target or Constraint to Be Reduced | Strategies Proposed |
|---|---|
| 1. Inadequate number of community health workers to work with health post staff to promote breastfeeding and the use of ORS in managing childhood diarrhea cases. Ratio of community health workers (CHWs) to households is 1 to 250. Target is 1 to 100 households. | ■ Advocate to community and district officials for the immediate recruitment and training of more CHWs.<br>■ Organize community-level action led by women's groups.<br>■ Seek cooperation and support from other groups, such as workplaces, schools, clubs, and cooperatives. |

The MPI team can use a table like the following one to consolidate the strategies for performance improvement. Number each strategy to correspond to a service target. Indicate the facilities and staff needed to implement each strategy. *In this example, other strategies might include training health workers, improving community water and sanitation, managing the supply of ORS, and setting up emergency transportation of sick children.*

**Strategy Description**

| Description | Involved Facilities and Staff |
|---|---|
| 1. Strengthen community health education through advocacy and action to recruit and train more CHWs, particularly in underserved communities. Obtain or produce health education materials. Train facility staff in counseling mothers on breastfeeding and use of ORS. Foster community health education activities for improving community water and sanitation, and increasing breastfeeding and use of ORS in home diarrhea management. | ■ MPI managers, health center treatment teams, health post staff, sanitarians, community leaders |

## Step 6: Create the Performance Improvement Plan

In step 6, the team designs an approach for implementing their performance improvement strategy. For each element of their strategy, the team lists the development and implementation activities they have identified as necessary to operate the improved services. The implementation activities and products should be defined as specifically as possible because this plan will be used for management and monitoring. *For example, products such as documentation or numbers of staff to be trained should be shown*. Indicate who is responsible for each activity and product, and note critical resources and their sources. Specify the start and end date of every activity. *In Indonesia, this step also produced individual performance targets for each priority subdistrict area*.

## Performance Improvement Plan

**Performance Improvement Manager:** Dr. Gómez

| Strategy Element | Performance Improvement Activities | Planned Products | Person Responsible | Critical Resources | Sources of Resources | Time Frame | |
|---|---|---|---|---|---|---|---|
| | | | | | | Start Date | End Date |
| Improve the management of diarrhea cases | Develop procedures to guide providers on proper management of childhood diarrhea, including counseling and use of ORS. | Procedures and training materials about diarrhea case management, ORS, and counseling of mothers | Mrs. Ramos | | | 1/10/05 | 10/16/05 |

## Step 7: Prepare the Budget

The team has to determine how implementing the performance improvement strategy and achieving the service performance targets will affect the routine operating budget. *For example, increasing the number of clients served may result in increased costs for medicines and supplies, other expendable materials, and travel.* The cost of resources needed to deliver additional services represents the additional funds needed, or column three (additional volume) multiplied by column six (unit cost) in the following example.

## Service Budget Reflecting Supplement Needed for Performance Improvement

| Essential Service | Current Service Volume | Additional Volume | Total Service Volume | Critical Resources | Unit Cost | Total Cost | Current Funding | Additional Funds Needed |
|---|---|---|---|---|---|---|---|---|
| 1. Community education on ORS and breastfeeding | 70,000 | 20,800 | 90,800 | Materials | $.44 | $9,152 | 0 | $9,152 |

## Step 8: Prepare an Advocacy Plan

At this point, the team can prepare an advocacy plan to include in its proposal for performance improvement. *In Indonesia, because of the rapid pace of decentralization, the managers of the MPI process suggested that district teams needed to devote special attention to obtaining support from the District Planning Office and other sources of financial and material support. For that reason, they asked the teams to prepare an advocacy plan. This plan identified the issues and needs for special promotion activities, the targets of the efforts, the activities and materials needed for each promotion effort (data, special presentations), and the persons responsible.*

## Step 9: Design a Monitoring Framework

As the MPI team uses appropriate indicators and data produced during the performance assessment to define problems, objectives, and strategies, these indicators are refined. In step 9, the team reviews them and places them into a monitoring framework called the Health Watch Form. The purpose of this step is to confirm indicators of three or four categories that will be used for monitoring throughout the implementation process. Along with the table of objectives and targets, this framework becomes the basis for evaluating the performance improvement results. The Health Watch Form is usually presented on one page and contains sets of indicators for monitoring the health situation, service performance, constraint reduction, and implementation progress.

**Performance Improvement Monitoring Framework (Health Watch Form)**

| Health Trends | | | | Service Performance Trends | | | | Constraints and Implementation Progress | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Baseline | Objective | Year 1 | Indicator | Baseline | Target | Year 1 | Indicator | Baseline | Target | Year 1 |
| Cases of severe diarrhea (U5) | Estimated 200 per year | Reduce by 50% to 100 | | Inspection of community water and sanitation | 25% of villages | 75% of villages | | No. of sanitarians trained in inspection of water supplies | 2 | 10 | |
| % infants < 6 months exclusively breastfed | 40% | 80% | | Families educated on value of breastfeeding | 35% | 80% | | % of mothers aware of diarrhea prevention, management | 15% | 75% | |

The team also describes the assessment and sampling methods they will use in carrying out scheduled performance assessments, building on the experience they gained during the initial assessment. They should decide who will collect data and how often, and determine the action steps they will take in response to monitoring results. *For example, in Indonesia, rapid assessments of all health centers, village midwives, and households are conducted. Lot quality assurance sampling (LQAS) is used for midwives and women who have delivered in the past 12 months.* (See Chapter 9 in Rohde and Wyon 2002 for information on LQAS.) *In the Philippines, teams have used community-based monitoring of all households (married women of reproductive age and children under five), conducted by volunteer health workers, who are responsible for about 30 households each.*

If the health problem being addressed in the performance improvement effort contains aspects of continuous surveillance of health conditions, disease outbreaks, or risk factors, the team must describe the surveillance procedures (case definitions, methods and sources of notification information, follow-up investigation, and action-taking). *An example is the procedures for notification of maternal and neonatal deaths, conducting facility audits and verbal autopsies, analyzing the causes of the deaths, and taking corrective action*. The team will also plan to set up an improved surveillance system for selected conditions early in the implementation phase.

## Step 10: Prepare the Proposal

In the final step of the MPI planning phase, the team prepares a proposal to use to mobilize support and resources to carry out its plans. The proposal should include a one-page executive summary, most of the completed forms, and short explanations of and justification for the objectives, targets, strategies, budget requirements, and implementation plan. The proposal should be concise (about 20 to 30 pages), and use annexes for supporting materials (such as detailed data, maps, illustrative education materials, and documentation of procedures).

At the end of the planning process, the decision-makers return to hear the results of the teams' work and offer comments and encouragement before the teams begin to carry out their plans. The teams use their proposals to advocate for their ideas with local politicians and funding offices. They may have to seek support from communities and the private health sector. They sometimes need to modify their plans because of unforeseen difficulties and constraints.

## Managing Implementation

MPI does not end when assessment and planning are complete. Facilitators visit the teams periodically to monitor their progress and problems. Each team also monitors its own progress and the performance of services using the monitoring framework and forms they designed during the planning phase. At a determined time during the planning phase, the teams evaluate their implementation progress and difficulties and report back at a meeting of all the teams.

### Overcoming Common Obstacles to Implementing MPI Plans

The following kinds of difficulties often arise as districts complete their performance improvement planning and enter into implementation. If you are a provincial or district manager, you and the facilitators can help resolve these problems.

**Decision-makers disagree with the proposed strategy or fail to support it.** You can usually resolve this problem by negotiating between the district team and the concerned official in the MOH or national program, sometimes through arbitration. Decision-makers often withdraw their objections once they understand the quality of the analysis and local interest in the proposed strategy.

**Lack of resources delays implementation.** Facilitators should emphasize that teams can begin implementing their plan without more resources, while advocating for the inputs needed for full implementation. Some district MPI efforts have been carried out—and succeeded—without additional resources from the MOH.

**Teams neglect implementation because of other work.** You and the facilitation team should frequently visit the district teams as they begin implementation, to provide support and encouragement. Facilitators should tactfully remind the teams that they are scheduled to carry out monitoring and evaluation at specified times and that their performance will be compared with that of other participating districts. However, it is ultimately the responsibility of the local (district) health authority to ensure the success of the performance improvement effort.

**The process is not integrated into planning and budgeting.** In some countries, MPI has been introduced as supplemental to comprehensive health-sector planning and budgeting. In these countries, the process helps a district prioritize its health problems and plan and budget to resolve only the highest-priority problems. Help teams incorporate the MPI plan and budget into the district's annual plan and budget to sustain it for as long as the process is needed.

**Newly autonomous districts are reluctant to share.** Decentralization often leads to the need for partnerships or agreements between different levels of government and between local governments to share resources and responsibilities. Newly autonomous districts, especially wealthy ones, are often reluctant to share their resources or relinquish any of their autonomy, and the central government may be accustomed to dictating the terms of partnerships. You will need to clarify roles and responsibilities between different levels of government or local governments through memoranda of agreement.

**The monitoring framework is not implemented.** The improved use of routine data is a key product of MPI but needs continuous support. Advise each district team of the importance of immediately beginning use of its performance indicators and routine data sources to monitor progress. Schedule special events with the district team to help analyze and present data on monitoring.

## INTEGRATING MPI INTO DECENTRALIZATION EFFORTS

The Ministry of Health (MOH) of Indonesia, with assistance from MSH, is developing the capacity of district health offices to assume more responsibility in the context of the rapid decentralization taking place across most government sectors. This decentralization activity has benefited most from the application of Proses Peningkatan Kinerja (PROSPEK), the Indonesian name for MPI.

**Establishment of obligatory functions.** The government developed a conceptual and policy framework to guide the entire health sector in defining and pursuing obligatory functions (the Indonesian term for EPHFs). Each health function has minimum service standards, often expressed as population coverage indicators and targets. This set of obligatory functions clarifies districts' primary responsibilities in public health and provides the foundation for assessing district service performance and identifying services most needing performance improvement. The MOH will continually review and update the list of obligatory functions and standards to keep pace with the changing epidemiological, social-behavioral, economic, environmental, and political-administrative situation in Indonesia.

**Rapid assessment and determination of problems.** Participating districts used detailed guidelines, forms, and technical information to carry out MPI, with help from a small group of central and provincial facilitators. In the performance assessment phase, the district teams assembled existing data related to the health problems and services in the list of obligatory health functions and identified 6–10 problems and services that they felt most deserved in-depth performance assessment.

The teams designed a rapid assessment to collect data in communities and peripheral facilities to determine the level of performance of the selected essential services and to estimate the extent of the health problems in the districts. The district teams also identified those subdistricts or catchment areas that are serving the poor and vulnerable in communities in greatest need of performance improvement. The districts then chose the two health problems that most needed attention and the related essential services, which became the focus for performance improvement planning. Examples include maternal deaths and pneumonia in children under five.

**Problem analysis and strategy design.** The district teams analyzed the problems, set objectives and targets for district performance improvement, identified resource needs, generated ideas for solving problems, and designed intervention strategies. *The diagram on page 20 illustrates the problem analysis and strategy design for MPI in one district of Indonesia.* The team used the selection criteria shown to choose two priority problems: tuberculosis and maternal and neonatal deaths. The figure shows the process for maternal and neonatal health (MNH) services. The *performance gap* is the difference (44%) between actual performance (46%) and desired coverage (90%) with emergency obstetric care.

The teams prepared an implementation plan, budget, and monitoring framework. They also formulated an advocacy plan. The last step was preparing and presenting their proposals. District leaders opened the planning process and attended the closing when the proposals were presented. Facilitators made every effort to engage both political leaders

and technical managers in the process, to gain their support from the outset.

**Implementation and evaluation phase.** The district teams' first activities aimed to mobilize critical resources and obtain community support and participation. In the following year, after receiving allocations from the central government, they began implementing the interventions and using their monitoring procedures. After about 12 months, the district teams carried out their predesigned evaluations to assess implementation progress, resource mobilization, service performance, and health impact. They shared their evaluation results with other districts, MOH leaders, and USAID representatives.

**Results of MPI.** In less than two years, the MPI process has enhanced data use as teams collect or assemble, analyze, and present data and use data for decision-making. They also design monitoring and evaluation schemes. The project has engaged 15 districts from five provinces of the country in MPI, and the methodology is being used in schools of public health. Other implementing agencies of USAID and other donors are funding expansion of the process in the provinces and districts they assist. The MOH is institutionalizing the MPI process in the health system and has designated it as the district performance assessment, planning, and implementation process for Indonesia.

## Frequently Asked Questions

Whether you are carrying out MPI for the first time, considering how to adapt the process, or deciding whether to use it, you can explore your options by reading the following questions. You should also distribute these questions and answers to decision-makers and facilitators.

**Is it better to assign a specific health problem to a district or allow the district to choose its own?** It is ideal to ask districts to choose the health problem and essential services they feel most require performance improvement from a set of essential services and functions. If participating districts can select a problem on which to focus performance improvement efforts, they can assume more responsibility for health planning.

Assigning a specific, relevant health problem to each district, however, reminds the district team that their performance and the epidemiological situation in their district are being monitored at the central level and that they are part of a national health system in which district health services must address priority health problems and objectives for health and service improvement.

Sometimes the services to be improved are assigned because a donor focused on specific services is funding the MPI effort. This focus takes decision-making out of the hands of the central ministry as well as the district health managers. Although this approach does not foster self-determination by the district, you can still apply the MPI approach successfully, as long as the details of the strategic solutions are left to the district to work out.

**Should districts address only one health problem at a time?** Because basic packages of services and public health functions are common, districts usually focus on two to four health problems and related services in doing MPI. But districts should still limit MPI to a few high-priority problems and services, so progress can be achieved in a short time and the district team feels a sense of accomplishment and confidence based on this success.

## Problem Analysis and Strategy Design: Example for Maternal and Neonatal Health (MNH)

**Identify and Prioritize Gaps in Performance of Essential Health Services in Ritara District, Indonesia**

**Selection Criteria**
- Epidemiology
- Performance rank
- Public good
- Intervention feasibility
- Cost-effectiveness

**Obligatory Functions and Minimum Standards for MNH Services**

| Essential Life-Saving MNH Services | Performance Gap |
|---|---|
| ■ Provision of functional basic emergency obstetric and neonatal center (EONC) facilities | 87% |
| ■ Health promotion on preparedness for complications of pregnancy/delivery and postpartum period | 50% |
| ■ Management of obstetric complications in EONC facilities | 44% |
| ■ Provision of neonatal care by trained health staff | 37% |

**Essential MNH Service Selected for Performance Improvement**

Management of obstetric complications in EONC facilities

**Demography and Infrastructure**
- poor population
- vulnerable groups
- inadequate distribution of facilities
- inadequate transportation

**Performance Improvement of EONC Services, Ritara District**

**Expected Results**

District target: 90% of obstetric complications are managed in EONC facilities

**Performance Gap**

44% under target for percentage of obstetric complications managed in EONC facilities

**Achievements**

Only 46% of obstetric complications are managed in EONC facilities

**Main Causes**
- Number and geographic distribution of functional basic and comprehensive EONC facilities are inadequate
- Midwives and basic EONC facilities are inadequately supplied with drugs and equipment
- Physicians at the basic EONC are not trained in management of obstetric complications
- Mothers lack information and resources to prepare for complications

**Priority Intervention Strategy**
- Classify EONC drugs as vital in vital-essential-nonessential (VEN) system; forecast quantities required for EONC facilities and midwives; procure and distribute buffer stocks.
- Establish technical team (District Health Office, hospital, Ass'n of Obstetricians and Gynecologists, Ass'n of Midwives) to audit service performance and retrain providers on causes of and methods for preventing severe maternal and neonatal complications and deaths.
- Identify and conduct in-service training of midwives and EONC facility staff.
- Expand promotion of family and community readiness to recognize and manage life-threatening obstetric complications.
- Revise procedures to ensure proper and timely EONC referrals.
- Procure and make operational equipment at EONC facilities failing inspection.

**Goal**

At least 90% of women with life-threatening complications will be managed in EONC facilities with essential EONC drugs and equipment.

**Is it better to limit the amount of resources districts can expect for their proposals?** In the 1980s and 1990s, when districts in Asia and Africa that were using MPI were told that they would not receive additional resources to carry out their plans but had to make the best use of what they had, they became very innovative and efficient. More recently, MPI has been implemented in the context of donor-funded bilateral projects or MOH grant programs, so some supplemental resources could be mobilized for sound district proposals. It is not clear whether districts have achieved more using supplemental resources, even with incentives for improving performance. Since this practice can lower the sustainability of the effort, MPI practitioners favor making only limited supplemental resources available.

**How can new activities be funded?** Although you and your staff may believe you can deliver only fully budgeted services, this view limits the imagination of service staff and leads them to disregard their responsibility to deliver essential health services to the entire population. *For example, if the planned expansion of service coverage creates increased requirements for medicines and other supplies, or travel expenses of staff, the team can ask for a special allotment for the first year of implementation*. Sometimes the district health office can reallocate budgets across program areas. Or you can send a request for funding to the mayor, district administrator, governor, an NGO, donor, or the community to implement new strategies. For more information, please refer to the issue of *The Manager* entitled "Mobilizing Local Resources," vol. 11, no. 2, 2002.

**How can MPI be linked to and eventually integrated into routine district planning and budgeting?** This integration requires local solutions, depending on the nature and timing of district planning and budgeting. Each country varies in the amount of detail required from its district health offices and health facilities for operational and development budgeting. This requirement is influenced in turn by the degree of decentralization and the extent to which centrally managed programs are actively funding and managing activities in the district.

Annual budgeting occurs at the same time each year, sometimes with annual operational planning. Since MPI takes place at various times in the year, the results cannot always be used in the same year's annual plan and budget. Sometimes the results of MPI planning and budgeting can feed directly into the annual budget and help to realign resources to support the intensive efforts and expanded services expected to result.

**How can MPI be adapted?** Adaptations of MPI should follow the basic process of problem definition, objective and target-setting, strategy design, and implementation planning, and the process should be entirely carried out by the district teams. Within that structure, many variations are possible.

Teams can do a detailed assessment. They can assemble existing data, and design and conduct rapid surveys to evaluate the current performance of selected essential services, to obtain more and better data for planning.

Another variation is to stop the planning process after the initial problem analysis and objective setting to allow the district teams to collect more information and gather ideas from local facilities and communities for improving service performance. The second round of planning then focuses on designing solutions.

**How can I obtain support from district politicians?** Use every opportunity to interest and engage local politicians in the process of health improvement and service problem-solving. Stress this engagement as preparations are being made in the district to carry out the performance assessment. When the results of the assessment are known, invite political leaders to participate in the selection of the priority problem and related services. Ask them to sponsor and open the planning process and attend the closing. If these leaders are in a position to mobilize needed resources, arrange special presentations for them to confirm the benefit expected from these investments. Associate the names of supportive politicians with the progress and results of the implementation efforts. *In some Philippine municipalities, the mayor started the development effort and inspired the team to develop local solutions.*

**What should I do if a district proposes interventions that differ from national policy?** Allow the ideas of the district to be tried and assessed for their effectiveness. It is important to encourage innovations in involving the community and private health sector and establish partnerships with the public health services to maximize coverage with essential services. Sometimes such innovations lead to strategic breakthroughs that are eventually written into policy. *For example, in Ghana, an innovation using community health nurses in a remote area was so successful that it became the basis for national policy (Kolehmainen-Aitken 2004)*. If the proposed intervention has a chance of succeeding, the national health administration should treat the district's efforts as a type of action research. If the proposal presents risks to the population's health, however, the team must take a risk-free approach.

## EXPANDING COVERAGE AND QUALITY THROUGH A MATCHING GRANT PROGRAM

In 1999, the Department of Health (DOH) in the Philippines launched a matching grant program to help municipalities and cities expand service coverage and quality for women and children in the context of a decentralized health system. From 1996 to 2004, with assistance from MSH, a USAID-funded project in the Philippines designed and put in place the matching grant mechanism for enhancing the performance of selected, highly cost-effective public health services across a large number of local government units (LGUs) in all regions of the country.

**The Matching Grant Program.** Under the Matching Grant Program, the DOH provided small grants of approximately $5,000–10,000 to interested LGUs through its regional offices. An LGU had to match at least 25% of the grant. The combined funds were used to help health services meet quality certification requirements, enroll indigents in the national health insurance program, assess unmet need and facilities, and prepare a plan for improving coverage and quality.

**Learning by doing.** The Program Management Technical Assistance Team (PMTAT) devised needs assessment tools and a planning process based on MPI methods. PMTAT and regional facilitators provided minimal facilitation and extensive materials. The LGUs in the program participated in an orientation to the Matching Grant Program, preparation for data collection and needs assessment, data collection and analysis, and planning and implementation of interventions. Some LGUs also designed and implemented a community-level disease surveillance system.

The services to be enhanced through the program included modern family planning, tetanus toxoid vaccination for pregnant women, childhood immunization, and vitamin A supplementation.

**The planning process.** The next phase engaged the LGU teams in a 4–5-day analysis and planning process to prepare them to create their own plans for addressing unmet needs and dramatically raising service coverage. Each LGU planning team presented its proposal and performance improvement plan to its own mayor and sought support for the plan.

**Results of the program.** Regional and provincial supervisors monitored LGUs' implementation of their plans and reviewed performance reports. Occasionally, LGU teams met to review progress and identify problems and solutions. The PMTAT project engaged more than 450 LGUs, representing about one-third of the total national population, in the program. Over half of these LGUs succeeded in having at least one facility certified. Three-quarters of the LGUs succeeded in enrolling more than 400,000 indigents in the national health insurance program. The success of LGUs is all the more meaningful because, in the last year of the project, the regional and provincial health offices did most of the facilitation.

One innovation of this project was a community needs assessment survey carried out by volunteer community health workers (CHWs). This community-based monitoring system was based on family profiles completed by CHWs. The survey identified unmet needs in each community. CHWs summarized these and issued client "call cards" to the mothers in each family with unmet needs, inviting the women to come to the facility for services. The planning process prepared the LGU teams to undertake the community needs assessment and summarize the data. The teams also learned how to assess facilities according to the criteria of the national quality assurance program for health care.

## USING A PROVINCIAL PLANNING AND MONITORING SYSTEM IN REBUILDING A HEALTH SYSTEM

The MOH is reconstructing the health system and expanding health services in post-conflict Afghanistan, with support from the USAID-funded REACH Project. The project aims to:

- build the Ministry's capacity to organize a decentralized health system;
- conduct a national survey of health resources as a basis for planning;
- organize provincial planning processes;
- establish a basic package of health services;
- rapidly expand health services through performance-based grants to NGOs;
- explore options for community-based health care;
- ensure the availability and appropriate use of medicines.

**Decentralized service planning and management.** After an initial survey of health resources and facility needs, the MOH began to decentralize service planning and management to the 32 provincial health offices that are responsible for delivering services to the 25 million people of Afghanistan, 85% of whom live in rural areas. The basic package of health services, which identifies three types of services to be delivered by community health care facilities and staff, became the foundation for decentralizing service planning and management to the provinces. A basic health information system is being put in place to record and report the extent to which the basic package of services is being delivered.

**The provincial health planning process.** National and MSH facilitators have designed a provincial health planning process to engage provincial planning teams in:

- assembling, analyzing, and presenting existing data on the health situation, service performance, and available resources, using standard forms;
- defining priority health problems and service constraints, setting health improvement objectives and service performance targets, and generating ideas for performance improvement;
- assessing operational needs and gathering ideas from field staff and communities for improving coverage with the basic package of care;
- designing interventions, and estimating facility, equipment, and staff development requirements;
- preparing the annual implementation plan, budgets, and provincial monitoring framework, and submitting the plan to the Ministry;
- monitoring implementation performance improvement, while strengthening health surveillance, service supervision, management of logistics, and other essential support systems.

The MOH has confirmed that the MPI approach is its tool of choice for creating a decentralized health management and performance improvement system in Afghanistan, and all provinces are scheduled to complete the MPI process in 2004.

## Sustaining District MPI

After several cycles of MPI, you can begin to institutionalize its development and maintenance. Creating regional and provincial facilitators is critical for sustaining the process. Ideally, the ability to facilitate the process and to improve the assessment and planning guidelines should be institutionalized within a national institution responsible for health planning in the country. The process, procedures, and forms can also be used in distance learning and degree programs and for in-service training.

The major factor leading to sustainability of the MPI process is early success in districts. To sustain MPI, you should:

- seek and maintain the support of senior health-sector leaders and program managers;
- expand the corps of facilitators by involving public health institutions and schools of public health and regional and provincial supervisory staff;
- involve local governments that express interest in the process;
- encourage decision-makers to apply MPI in new districts to develop and institutionalize the process nationally;
- identify an institutional home for maintaining and supporting the process and integrating it into routine planning and budgeting;
- provide support and encouragement to districts as they implement their plans. Publicize achievements locally, nationally, and to donor agencies through news bulletins and alerts about breakthroughs;
- convene periodic monitoring and evaluation conferences at which senior staff and politicians can witness districts' progress and the problems they are encountering;
- collaborate with other agencies and organizations to extend the process into their operational areas in support of performance improvement activities.

In general, the sooner providers of financial and technical assistance wind down their involvement, the better, as long as the required steps for institutionalization have been taken.

### Reviewers' Corner

*A forum for discussing concepts and techniques presented in this issue*

**On factilitators…**

*A reviewer points out that* "Experience from Indonesia suggests that some of the best facilitators come from the districts themselves."

**On district planning in South Africa…**

*Another reviewer describes this experience:* "Through the USAID-funded Equity Project, more than 300 district managers in three provinces conducted situation analyses and developed health plans. The process focused on empowering managers to analyze and address problems and on improving the linkages between finances and service delivery.

The results were gratifying. For example, one district in Mpumalanga conducted a situation analysis and realized that problems with the roads, clinic equipment, staff shortages, and availability of medicines were contributing to a high perinatal mortality rate. Knowledge, attitudes, and practices of local mothers were also a factor. The managers made a plan to improve education in the community and to reprioritize the budget to address these problems.

The general manager of a hospital in North-West Province said the process 'helped identify our biggest gaps. Before, we wouldn't consider where the money should go. There was a general lack of knowledge and our priorities were misplaced.' The process also allowed managers to address the waste of scarce resources. A manager in Mpumalanga commented: 'One town clinic had lower client numbers but was spending too much on medications. We asked the management to review medications ordered by the clinic.'"

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# Checklist for Managing Performance Improvement of Decentralized Health Services

If you are a national, regional, or provincial health manager, you should:

- Focus district performance assessment and improvement on the achievement of specific health objectives.
- Link performance improvement efforts to defined national service responsibilities (essential public health functions and basic packages of health services).
- Tailor the MPI process to serve the national health system, taking policy reform and decentralization requirements and conditions into account.
- Design structured phases and steps for the assessment and planning process, supported with forms for presenting data, results of analysis, and planning products. Prepare clear guidelines for the process.
- Use a low-profile style of facilitation to ensure that MPI teams carry out all analysis, intervention design, and planning tasks through a learning-by-doing process.
- Foster the institutionalization and sustainability of the process by:
  - securing the interest and support of political and technical health leaders from the outset;
  - mobilizing and preparing national and regional facilitators;
  - finding and supporting an institutional home to develop, support, and maintain the MPI process;
  - integrating the process into annual district planning and budgeting;
  - expanding to districts that represent the country's diversity or have expressed interest in MPI.

If you are a district manager, you should:

- Prepare for and support the assessment, planning, implementation, and evaluation process.
- Work with your district team members during implementation to make sure that they are making progress in carrying out their performance improvement plans. Help them address unforeseen problems and mobilize resources if necessary. Motivate them by publicizing their successes.

THE MANAGER

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CASE STUDY FOR TRAINING AND GROUP DISCUSSION

# Landung Districts Become Leaders in Improving the Performance of Health Services

**Scenario** THE DIRECTOR FOR HEALTH Services in Landung was concerned that district managers were having difficulty reaching national standards for essential public health functions (EPHFs) within their current budgets. He wanted them to meet their performance expectations without asking for budget increases. He was certain that if district managers could learn to identify and solve their performance problems themselves, they would become more engaged in carrying out their EPHFs, achieve their performance objectives, and use their existing funding more effectively.

The Director called on the Public Health Institute to devise an assessment and planning process that would strengthen the capacity of district health teams to analyze their local situations and design their own interventions to solve performance problems. The Public Health Institute chose the management of performance improvement (MPI) process for this purpose. To initiate the process, the Director chose three districts with prevalent maternal and child health concerns: Ritara, maternal deaths; Jambuku, malaria; and Bantalan, measles.

During a workshop facilitated by the Public Health Institute, the three district teams undertook a 10-day situation analysis and planning process. On the last day, the teams presented their proposed solutions for improving the three services to a panel of national program directors. Each director pointed out that the proposed solution included an approach that went beyond current Ministry-approved practice. They expressed concerns about these approaches but agreed to approve their use by these districts as part of the MPI process. They acknowledged the need for districts to improve their effectiveness in carrying out EPHFs and stated their support for the Director in initiating MPI. Before leaving for their districts, the teams met to discuss what had happened.

"I was worried at first that the directors would not support our plans," said Dr. Nasar of Ritara.

"I guess it's no surprise that they expressed reservations about our approaches, since we were suggesting revisions to standard practices," said Mrs. Mahendra of Jambuku. "I'm just relieved that they are going to let us try these new service approaches."

Bantalan district's Dr. Yusril spoke next. "The program directors showed leadership in approving our plans as we designed them," he said with conviction. "I am confident that the process we went through to develop our strategies was rigorous. I am eager to put my district's plan into action." His colleagues nodded their assent.

One year later, the teams assembled again as planned to report the results of their approaches for improving the performance of their assigned services. The Ritara team presented its results first. "In the year before MPI, there were 10 maternal deaths in Ritara District," said Dr. Nasar. "Seven were caused by postpartum hemorrhage that was uncontrolled before the women reached the hospital for emergency treatment. Our strategy involved flagging the records of pregnant women consid-

ered to be at high risk for complications, visiting homes to convince husbands and mothers-in-law about the importance of women delivering in a hospital, equipping our health center vehicles with IV kits, and training drivers and attendants to begin administering IV fluids to women who were having postpartum hemorrhage on the way to the hospital."

Mrs. Maryono of the Ritara team rose to speak. "Our mandate was to come up with innovative ways to reduce maternal mortality in Ritara, test them over 12 months, and evaluate their effectiveness. The government's service standards for emergency obstetric care do not include training vehicle attendants to administer IV fluids, and we appreciated the program manager's support in allowing us to carry out our solution as planned. We have fulfilled our mandate as well as we could, and we think you will be pleased with the results."

"During the 12 months we spent implementing our interventions, there were no maternal deaths in Ritara," continued Dr. Nasar. She had everyone's attention. "Our evaluation found that some interventions were more successful than others. For example, our family education visits did not convince women at high risk of complications to deliver at the hospital. So we couldn't reduce the need to provide emergency obstetric care at the community level. Even educated women in Ritara told us that 'the hospital is where people go to die,' and families continued to express concerns about the quality of care there. However, providing IV fluids for women suffering from postpartum hemorrhage while they were traveling in our vehicles between the community and the hospital meant that no woman in Ritara died from postpartum hemorrhage because of lack of access to transfusions or other needed care."

"Do you think your strategy was responsible for this remarkable reduction in maternal mortality?" asked Mrs. Sofwan, Program Director for Maternal and Child Health.

"It is too early to tell whether this change in maternal deaths is due to our interventions," replied Dr. Nasar. "We need to investigate whether any other factors contributed to the reduction in deaths and observe the data for a longer period."

"How did you fund your strategy?" asked a participant from another district. "The district already had vehicles, drivers, and attendants," replied Mr. Wahid, the team's financial management member. "The IV kits were not expensive, so we were able to buy them using our existing budget. And the record-keeping changes and education visits to families were all within our means."

Presentations by the teams from Jambuku and Bantalan showed similar successes. For example, the Bantalan team had proposed a change in the immunization schedule for the second dose of the measles vaccine for children. The innovation not only increased adherence—it also helped the district achieve the national standard for measles immunization without increasing costs.

The Director spoke last. "These teams have clearly demonstrated the leadership role that Landung's districts can play in improving the performance of our health sector. I will seek input from the Public Health Institute, program directors, and others to expand the MPI effort and determine whether any of these teams' innovations can and should be adapted for wider use." He thanked the program directors for their support, and then nodded to the team members. "Congratulations, and keep up the good work."

## Discussion Questions

1. What factors may have contributed to the effectiveness of the MPI process in Landung? How does the MPI process differ from other district planning processes?
2. Discuss the effectiveness of the interventions applied by the Ritara team. Do such experiences justify changing service policies and procedures?
3. Based on the experience described in the scenario, what factors need to be in place to apply MPI? Explain your thinking.

## Case Analysis

### QUESTION 1 What factors may have contributed to the effectiveness of the MPI process in Landung? How does the MPI process differ from the other district planning processes?

A major factor in the effectiveness of Landung's district team problem-solving process was the support of the Director. He initiated the process, and it is clear that he was pleased with the results and will support expansion of the effort. Support from program leaders allowing the district teams to implement their solutions as planned was another major factor.

Other factors include the following:

- The teams went through a rigorous process of identifying factors contributing to their problems and finding new ways to deliver services. This process unleashed their creativity. It helped them feel confident about the validity of their innovative service approaches and motivated to implement them.
- This learning-by-doing process was real, not just a training exercise. Because the team members did the work themselves, they "owned" the products.
- The teams gathered, analyzed, and quantified data at every step of the way. Their "before" and "after" data appear to demonstrate the effectiveness of their interventions, although the team is correct about the need to observe the trend over a longer period and investigate whether any other factors may have changed in their district's environment.
- By telling the districts what health problems to focus on, the Director impressed upon districts that the Ministry was monitoring their epidemiological situation and service performance and that they were a part of a health system. Although it is usually desirable in the MPI process to let each team choose its own problem to work on, in this case the assignment of the health problem was effective because the strategic solutions were left to each district to work out.
- The process in each district focused on one high-priority problem and only a few services. Now each team will have the experience and confidence to apply this process to other problems and services.
- All teams were able to implement their interventions using existing resources.

The process applied in Landung differs from other district planning processes because, although supported at the central level, it encourages district teams to develop solutions based on their own analysis of data and causal factors. This type of "bottom-up" approach is more effective than orders from higher up. Teams also focus on only one important problem, rather than all services.

### QUESTION 2 Discuss the effectiveness of the interventions applied by the Ritara team. Do such experiences justify changing service policies and procedures?

In the scenario, Dr. Nasar points out that some interventions appeared to be more effective than others. For example, the outreach efforts with families did not convince pregnant women at high risk of complications to deliver at the hospital. However, the intervention that enabled women to receive IV fluids while traveling to the hospital appeared to eliminate the incidence of maternal mortality due to postpartum hemorrhage. The district will need to determine whether any other factors contributed to this reduction in maternal mortality.

As for changing service policies and procedures based on this experience, the Director said that he would seek input from others to determine whether the interventions explored by the teams could be applied more widely. This approach is appropriate because it is gradual and inclusive. Authorities may also want to observe the districts' experiences over a longer period. They may consider applying the interventions in a few new districts and evaluate the experiences before making wider changes in service policies and procedures.

**QUESTION 3 Based on the experience described in the scenario, what factors need to be in place to apply MPI? Explain your thinking.**

Factors that need to be in place to apply MPI include:

- **Support from health leaders.** National authorities need to support this effort. They must be willing to let district teams develop and implement their own solutions to problems they identify and provide limited resources, if they are essential to implement the proposed interventions.
- **Facilitation.** A team of central and provincial facilitators should support the MPI process. If the facilitation team does not already exist, then it needs to be developed. The team must use a style of facilitation that focuses on learning-by-doing and encourages district teams to do their own analyses and come up with their own solutions.
- **Monitoring and evaluation requirements.** The facilitation team and others need to provide support and encouragement to the district teams during the implementation phase. District teams may be more motivated to carry out their plans if they are prompted about the monitoring and evaluation schedule and reminded that their performance will be compared with that of other participating districts at the end of the implementation period. Visits by facilitators, district managers, or others may help teams develop solutions to obstacles that arise during implementation.
- **The planning and budgeting process.** The MPI process and resulting strategies need to be integrated into district planning and budgeting.
- **A policy framework for essential public health functions.** Having in place a national policy framework that defines EPHFs across all health categories and defines district-level performance objectives is important in facilitating MPI. Such a framework conceptually organizes priority health problems, the services that manage those problems, and the specific tasks or services to be delivered to a percentage of the population. In the scenario, EPHFs and performance objectives have been defined at the central level, and the districts are expected to figure out for themselves how to fulfill their EPHFs and meet their performance objectives. Within this policy context, MPI offered districts an opportunity to identify factors contributing to a specific health problem, develop innovative local solutions, and implement them. MPI motivated the districts to be more assertive in working to reach national standards.

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